		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028860

Facility Name: Lexington Health Care Center-Lombard

Address: 2100 S. Finley Road (Number) Lombard (City) 60148 (Zip Code)

County: DuPage

Telephone Number: (630) 495-4000 **Fax #** (630) 495-2809

IDPA ID Number: 363252724001

Date of Initial License for Current Owners: 10/09/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,984	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,984	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,047	7,815	6,061	22,923	8
9	SNF/PED					9
10	ICF	30,702	17,684	625	49,011	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,749	25,499	6,686	71,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.74%

D. How many bed-hold days during this year were paid by Public Aid? 6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 10/9/84

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 31 and days of care provided 5,485

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	329,517	26,535	12,478	368,530		368,530		368,530			1
2	Food Purchase		265,309		265,309		265,309	(10,949)	254,360			2
3	Housekeeping	335,467	36,205		371,672		371,672		371,672			3
4	Laundry	23,893	34,912		58,805		58,805	(10,114)	48,691			4
5	Heat and Other Utilities			252,893	252,893		252,893	2,275	255,168			5
6	Maintenance	72,761		147,195	219,956		219,956	(9,458)	210,498			6
7	Other (specify):*											7
8	**TOTAL General Services**	761,638	362,961	412,566	1,537,165		1,537,165	(28,246)	1,508,919			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,684,209	214,997	30,682	2,929,888		2,929,888		2,929,888			10
10a	Therapy			486,670	486,670		486,670		486,670			10a
11	Activities	209,808	21,834	2,864	234,506		234,506	17	234,523			11
12	Social Services	27,222		2,100	29,322		29,322		29,322			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,921,239	236,831	534,316	3,692,386		3,692,386	17	3,692,403			16
	C. General Administration											
17	Administrative	128,344		399,657	528,001		528,001	(399,657)	128,344			17
18	Directors Fees											18
19	Professional Services			48,135	48,135		48,135	5,669	53,804			19
20	Dues, Fees, Subscriptions & Promotions			22,251	22,251		22,251	4,314	26,565			20
21	Clerical & General Office Expenses	327,548	33,188	18,698	379,434		379,434	18,624	398,058			21
22	Employee Benefits & Payroll Taxes			536,142	536,142		536,142	55,777	591,919			22
23	Inservice Training & Education							282	282			23
24	Travel and Seminar			2,715	2,715		2,715	516	3,231			24
25	Other Admin. Staff Transportation							8,852	8,852			25
26	Insurance-Prop.Liab.Malpractice			46,043	46,043		46,043	1,808	47,851			26
27	Other (specify):*											27
28	**TOTAL General Administration**	455,892	33,188	1,073,641	1,562,721		1,562,721	(303,815)	1,258,906			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,138,769	632,980	2,020,523	6,792,272		6,792,272	(332,044)	6,460,228			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington Health Care Center-Lombard #0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			52,398	52,398		52,398	150,554	202,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							224,282	224,282			32
33	Real Estate Taxes							139,048	139,048			33
34	Rent-Facility & Grounds			1,337,483	1,337,483		1,337,483	(1,337,483)				34
35	Rent-Equipment & Vehicles			1,694	1,694		1,694	385	2,079			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,391,575	1,391,575		1,391,575	(823,214)	568,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,269	16,241	119,510		119,510		119,510			39
40	Barber and Beauty Shops			31,500	31,500		31,500		31,500			40
41	Coffee and Gift Shops			818	818		818		818			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* Nonallowable costs			93,499	93,499		93,499	(93,499)				43
44	**TOTAL Special Cost Centers**		103,269	265,034	368,303		368,303	(93,499)	274,804			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,138,769	736,249	3,677,132	8,552,150		8,552,150	(1,248,757)	7,303,393			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(93)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,114)	4		8
9	Non-Straightline Depreciation	1,178	30		9
10	Interest and Other Investment Income	(37,835)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,608)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,561)	43		24
25	Fund Raising, Advertising and Promotional	(6,330)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(36,632)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(12,733)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,728)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,086,029)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,086,029)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,248,757)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 1/1/00

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health		
John Samatas	33.33%	See Attached Schedule B		Care Systems of		
Cynthia Thiem	33.34%			Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,337,483	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	$	$ (1,337,483)	1
2	V	19	Professional fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	80	80	2
3	V	21	Bank charges		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	450	450	3
4	V	30	Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	136,823	136,823	4
5	V	32	Interest expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	257,595	257,595	5
6	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454	6
7	V	33	Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	137,483	137,483	7
8	V	43	State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	9,632	9,632	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,337,483			$ 544,517	$ * (792,966)	14

** The owners of Lexington Health Care Center of Lombard, Inc. own 100% of Lexington Health Care Systems of Lombard Limited Partnership

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	**	$ 24,170	$ 24,170	15
16	V	22	FUTA		Royal Management Corp.	**	502	502	16
17	V	22	SUTA		Royal Management Corp.	**	1,347	1,347	17
18	V	22	Insurance - W/C		Royal Management Corp.	**	284	284	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**	12,224	12,224	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**	6,394	6,394	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**	4,025	4,025	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	2,235	2,235	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**	6,293	6,293	23
24	V	33	Property taxes		Royal Management Corp.	**	1,565	1,565	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**	1,289	1,289	25
26	V	26	Insurance - general		Royal Management Corp.	**	1,808	1,808	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**	583	583	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**	1,900	1,900	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**	375	375	29
30	V	11	Activities Consultant		Royal Management Corp.	**	17	17	30
31	V	35	Equipment rental		Royal Management Corp.	**	385	385	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	3,725	3,725	32
33	V	25	Auto expense		Royal Management Corp.	**	8,852	8,852	33
34	V	21	Bank charges		Royal Management Corp.	**	280	280	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**	5,478	5,478	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**	589	589	36
37	V	21	Office supplies & printing		Royal Management Corp.	**	7,108	7,108	37
38	V	21	Postage		Royal Management Corp.	**	2,653	2,653	38
39	Total			$			$ 94,081	$ * 94,081	39

** Certain owners of Lexington Health Care of Lombard, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	**	$ 1,282	$ 1,282	15
16	V	6	Security service		Royal Management Corp.	**	13	13	16
17	V	21	Telephone		Royal Management Corp.	**	7,588	7,588	17
18	V	21	Communications		Royal Management Corp.	**	545	545	18
19	V	24	Travel & seminar		Royal Management Corp.	**	735	735	19
20	V	32	Interest		Royal Management Corp.	**	2,068	2,068	20
21	V	23	Training & education		Royal Management Corp.	**	282	282	21
22	V	17	Management fees	399,657	Royal Management Corp.	**		(399,657)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 399,657			$ 12,513	$ * (387,144)	39

** Certain owners of Lexington Health Care of Lombard, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	5	10%	Salary	$ 28,057	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33%	See Schedule C	2	4%	Salary	12,470	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	5%	Salary	15,587	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4%	Salary	4,988	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4	10%	Salary	8,291	L 17, C 1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,393		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	81,984	$ 24,170	1
2	22	FUTA	Bed Days	788,945	11	4,830		81,984	502	2
3	22	SUTA	Bed Days	788,945	11	12,967		81,984	1,347	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		81,984	284	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		81,984	12,224	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		81,984	6,394	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		81,984	4,025	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		81,984	2,235	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		81,984	6,293	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		81,984	1,565	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		81,984	1,289	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		81,984	1,808	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		81,984	583	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		81,984	1,900	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		81,984	375	15
16	11	Activity consultant	Bed Days	788,945	11	167		81,984	17	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		81,984	385	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		81,984	3,725	18
19	25	Auto expense	Bed Days	788,945	11	85,184		81,984	8,852	19
20	21	Bank charges	Bed Days	788,945	11	2,695		81,984	280	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		81,984	5,478	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		81,984	589	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		81,984	7,108	23
24	21	Postage	Bed Days	788,945	11	25,535		81,984	2,653	24
25	TOTALS					$ 905,395	$		$ 94,081	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	81,984	$ 1,282	1
2	6	Security Service	Bed Days	788,945	11	127		81,984	13	2
3	21	Telephone	Bed Days	788,945	11	73,022		81,984	7,588	3
4	21	Communications	Bed Days	788,945	11	5,248		81,984	545	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		81,984	735	5
6	32	Interest	Bed Days	788,945	11	19,899		81,984	2,068	6
7	23	Training & Education	Bed Days	788,945	11	2,716		81,984	282	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 12,513	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lincoln National Life Insurance		x	Mortgage	$39,766.00	04/11/94	$ 3,978,766	$ 2,835,386	04/11/09	0.0875	$ 257,595	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$39,766.00		$ 3,978,766	$ 2,835,386			$ 257,595	9
	B. Non-Facility Related*											
10								Interest income offset			(37,835)	10
11								Amortization of mortgage costs			2,454	11
12								Allocation from management company			2,068	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (33,313)	14
15	TOTALS (line 9+line14)						$ 3,978,766	$ 2,835,386			$ 224,282	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 141,000	1
	Allocated from management company	1,565	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 135,483	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,952)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 143,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 139,048	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	125,750	8
	1996	126,636	9
	1997	130,718	10
	1998	134,318	11
	1999	135,483	12

1999 tax:	135,483
Estimated increase:	1.05
Estimated 2000 taxes:	142,257
Use:	143,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lombard Lexington Square Life Care, Inc.: Retirement Community and Assisted Living; 212 life care units and 51 assisted living units; 309,000 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1984	$ 616,761	1
2					2
3	TOTALS	30,000		$ 616,761	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1984	1984	$ 3,661,473	$		$ 104,614	$ 104,614	$ 1,697,787	4
5	9		1995	1995	284,156	8,119	35	8,119		44,653	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1990	96,217		10	4,809	4,809	96,217	9
10	Building Improvements			1991	71,493		10	7,149	7,149	67,917	10
11	Building Improvements			1994	20,200		10	2,020	2,020	13,130	11
12	Building Improvements			1995	14,535	415	35	415		2,284	12
13	Building Improvements - dishwater hood			1996	2,748	275	10	275		1,236	13
14	Building Improvements - outside painting			1996	11,308	1,131	10	1,131		5,089	14
15	Building Improvements - dining room			1996	3,752	375	10	375		1,689	15
16	Leasehold Improvements			1992	16,299	466	35	466		3,959	16
17	Leasehold Improvements			1994	21,836	2,184	10	2,184		14,194	17
18	Leasehold Improvements - 2nd floor			1996	19,319	1,932	10	1,932		8,694	18
19	Leasehold Improvements - bathroom rehab			1996	9,216	922	10	922		4,148	19
20	Leasehold Improvements - fan coil repairs			1996	6,669	191	35	191		826	20
21	Land Improvements			1993	2,985	199	15	199		1,493	21
22	Land Improvements			1995	4,596	306	15	306		1,685	22
23	Capitalized Repairs			1986	1,730		10			1,730	23
24	Building Improvements - basement			1996	18,993	1,899	10	1,899		7,122	24
25	Leasehold Improvements - Corner Guards			1997	520	52	10	52		182	25
26	Leasehold Improvements - Corridor flooring			1997	10,381	1,038	10	1,038		3,633	26
27	BI: Kitchen Rehab			1998	2,494	249	10	249		623	27
28	Wiring for MDS project			1998	3,365	337	10	337		842	28
29	Install Fire Sprinklers in Mechanical Rms			1998	4,600	131	35	131		328	29
30	Tile for Lobby			1998	20,530	2,053	10	2,053		5,133	30
31	Walk in Freezers/Coolers			1998	3,182	91	35	91		227	31
32	Fire Wall Repairs			1998	12,410	355	35	355		887	32
33	Underground storage tank			1998	2,613		10	262	262	786	33
34	Repave parking lot			1999	7,625	508	15	508		762	34
35	Lounge Floor Tile			1999	2,964	296	10	296		444	35
36	TOTAL (lines 4 thru 35)				$ 4,338,209	$ 23,524		$ 142,378	$ 118,854	$ 1,987,700	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Rewire Building			1999	9,083	260	35	260		390	9
10	Heat exchanger for water heater			1999	1,660		5	332	332	498	10
11	Compressor and tank for freezer			1999	2,924		5	584	584	876	11
12	Plumbing Improvements			2000	2,833	142	10	142		142	12
13	Relocate 2nd floor sprinklers			2000	2,200	31	35	31		31	13
14	Water heater repairs			2000	3,831	383	5	383		383	14
15	Automatic door			2000	4,556	65	35	65		65	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 27,087	$ 881		$ 1,797	$ 916	$ 2,385	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from management company			1995	10,578		35	327	327	1,662	9
10	Allocated from management company			1996	8,608		35	266	266	1,107	10
11	Allocated from management company			1989	297		31	9	9	121	11
12	Allocated from management company - HVAC			1998	223		35	7	7	19	12
13	Allocated from management company - Offices			1999	562		35	17	17	24	13
14	Allocated from management company - Offices			2000	267		35	8	8	6	14
15	Allocated from management company			1987	49,448		31	1,531	1,531	20,086	15
16	Allocated from management company			1993	26		39	1	1	5	16
17	Allocated from management company			1995	1,114		39	34	34	156	17
18	Allocated from management company			1996	223		39	7	7	25	18
19	Allocated from management company - Sidewalk			1998	466		39	14	14	28	19
20	Allocated from management company - Roof			1998	17		15	1	1	4	20
21	Allocated from management company - Awnings			1999	288		39	9	9	42	21
22	Allocated from management company - Parking lot			1999	131		15	4	4	5	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 72,248	$		$ 2,235	$ 2,235	$ 23,290	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 424,113	$ 27,160	$ 45,391	$ 18,231	10	$ 258,281	37
38	Current Year Purchases	11,328	833	833		5-10	833	38
39	Fully Depreciated Assets	958,299					958,299	39
40	Allocated from Management Company	62,003		6,293	6,293		43,878	40
41	TOTALS	$ 1,455,743	$ 27,993	$ 52,517	$ 24,524		$ 1,261,291	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Care	Chevy Van	1987	$ 20,061	$	$	$	5	$ 20,061	42
43										43
44										44
45	Allocated from Management Company			26,863		4,025	4,025		16,509	45
46	TOTALS			$ 46,924	$	$ 4,025	$ 4,025		$ 36,570	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	6,556,972	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	52,398	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	202,952	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	150,554	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	3,311,236	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,079 Description: Postage Meter - $658; Copier - $1,036; Allocated from Management Company - $385
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	18,082	$ 224,014	$	18,082	$ 224,014	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		1,599	15,776		1,599	15,776	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		23,956	246,880		23,956	246,880	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				103,269		103,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Clinitron Beds	L 39, C 3				6,921			6,921	13
	Other (specify): Oxygen / Laboratory	L 39, C 3				9,320			9,320	
14	TOTAL			$	43,637	$ 502,911	$ 103,269	43,637	$ 606,180	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 608,381	$ 619,207	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 234,386)	1,577,927	1,577,927	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,817	27,817	6
7	Other Prepaid Expenses	375	375	7
8	Accounts Receivable (owners or related parties)	56,572	56,572	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,271,072	$ 2,281,898	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		616,761	13
14	Buildings, at Historical Cost		3,661,473	14
15	Leasehold Improvements, at Historical Cost	506,986	776,071	15
16	Equipment, at Historical Cost	454,074	1,502,667	16
17	Accumulated Depreciation (book methods)	(433,174)	(3,311,236)	17
18	Deferred Charges		17,737	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs		20,453	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 527,886	$ 3,283,926	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,798,958	$ 5,565,824	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 255,357	$ 255,357	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	217,928	217,928	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,238	5,238	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,000	32
33	Accrued Interest Payable		14,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	160,639	151,391	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 639,162	$ 786,914	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,835,386	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,835,386	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 639,162	$ 3,622,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,159,796	$ 1,943,524	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,798,958	$ 5,565,824	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,891,832	1
2	Restatements (describe):		2
3	**Prior year post closing entries**	16,428	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,908,260	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,174,536	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,923,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 251,536	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,159,796	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,659,451	1
2	Discounts and Allowances for all Levels	(777,323)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,882,128	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	906,767	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 906,767	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,917	12
13	Barber and Beauty Care	39,188	13
14	Non-Patient Meals	93	14
15	Telephone, Television and Radio	246	15
16	Rental of Facility Space		16
17	Sale of Drugs	129,908	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,525	19
20	Radiology and X-Ray		20
21	Other Medical Services	207,427	21
22	Laundry	10,114	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 408,418	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	37,835	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,835	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bed Hold Revenue	491,538	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 491,538	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,726,686	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,537,165	31
32	Health Care	3,692,386	32
33	General Administration	1,562,721	33
	B. Capital Expense		
34	Ownership	1,391,575	34
	C. Ancillary Expense		
35	Special Cost Centers	245,327	35
36	Provider Participation Fee	122,976	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,552,150	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,174,536	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,174,536	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,966	2,095	$ 68,870	$ 32.87	1
2	Assistant Director of Nursing	5,246	5,511	125,228	22.72	2
3	Registered Nurses	44,456	47,495	1,004,752	21.15	3
4	Licensed Practical Nurses	14,476	15,604	302,968	19.42	4
5	Nurse Aides & Orderlies	95,495	99,976	1,064,402	10.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,813	9,639	117,989	12.24	8
9	Activity Director	1,920	1,977	25,546	12.92	9
10	Activity Assistants	21,100	22,250	184,262	8.28	10
11	Social Service Workers	1,868	1,940	27,222	14.03	11
12	Dietician	205	219	4,458	20.36	12
13	Food Service Supervisor	1,968	2,080	31,964	15.37	13
14	Head Cook	1,952	2,080	37,117	17.84	14
15	Cook Helpers/Assistants	14,288	15,542	140,499	9.04	15
16	Dishwashers	17,358	18,273	115,479	6.32	16
17	Maintenance Workers	4,386	4,687	72,761	15.52	17
18	Housekeepers	47,543	49,805	335,467	6.74	18
19	Laundry	3,454	3,648	23,893	6.55	19
20	Administrator	1,939	2,103	58,951	28.03	20
21	Assistant Administrator					21
22	Other Administrative	674	691	69,393	100.42	22
23	Office Manager					23
24	Clerical	19,425	20,479	327,548	15.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	308,532	326,094	$ 4,138,769 *	$ 12.69	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,478	L 1, C 3	35
36	Medical Director	Monthly	12,000	L 9, C 3	36
37	Medical Records Consultant	13	650	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,864	L 11, C 3	44
45	Social Service Consultant	Monthly	2,100	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	13	$ 31,292		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	285	4,486	L 10, C 3	52
53	TOTAL (lines 50 - 52)	285	$ 4,486		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Lee Luce	Administrator	0.00%	$ 2,127
Nancy McDonald	Administrator	0.00%	56,824
John Samatas	Admin/Plant Ops.	33.33%	12,470
James Samatas	Administrative	33.33%	28,057
Cynthia Thiem	Administrative	33.34%	15,587
George Samatas	Administrative	0.00%	4,988
Jason Samatas	Administrative	0.00%	8,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 128,344

B. Administrative - Other

Description	Amount
Management fees (eliminated in Column 7)	$ 399,657
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 399,657

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Insurance & Annuity Co.	401(k) Administration	$ 585
Altschuler, Melvoin & Glasser LLP	Accounting	13,486
American Express Tax & Bus. Svs.	Accounting	5,926
Christine Toolan, R.R.A.	Medical Records Consultant	60
Holleb & Coff	Legal	3,709
James Samatas	Legal	75
Personnel Planners	U/C Consultant	709
Royal Management Corp.	Web site development	338
Systematic Management	Billing Consultant	19,056
Freidman, Anselmo & Lindberg	Collections	1,171
AIM	Computer Consultant	2,153
Information Controls, Inc.	Computer Consultant	867
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 48,135

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,858
Unemployment Compensation Insurance	39,270
FICA Taxes	305,453
Employee Health Insurance	78,513
Employee Meals	10,856
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	16,389
Employee Transportation	89,334
Other Employee Benefits	11,246
TOTAL (agree to Schedule V, line 22, col.8)	$ 591,919

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	18,938
Health Care Worker Background Check	
(Indicate # of checks performed 90)	1,082
Miscellaneous Licenses & Permits	1,310
Miscellaneous Dues & Subscriptions	721
Allocated from Management Company	4,314
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,565

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,496
Allocated from management company	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,231

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance	1999	$ 2,219	36 mo.	$	$	$ 370	$ 740	$ 740	$ 369	$	$	$
2	Deferred Maintenance	3/1999	1,536	36 mo.			256	512	512	256			
3	Deferred Maintenance	9/1999	3,918	36 mo.			653	1,306	1,306	653			
4	Painting & Decorating	2000	16,681	36 mo.				2,780	5,560	5,560	2,781		
5													
6													
7													
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17													
18													
19													
20	TOTALS		$ 24,354		$	$	$ 1,279	$ 5,338	$ 8,118	$ 6,838	$ 2,781	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/00 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,301** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,976**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,856** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **93**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.